Patient Information as of \_\_\_\_\_\_\_\_ (enter today’s date)



Please Print Legibly & Fill In or Correct Fields

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient’s Name** | | | |  | | |  | | | | | | | |  | |
|  | | | | Last | | | First | | | | | | | | Middle | |
| Address |  | | | | | | |  | | | |  | | |  |
|  | Street & Apt # | | | | | | | City | | | | State | | | Zip |
| Home Phone | |  | | | Cell Phone | |  | | | Pharmacy | | |  | | |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |  | |
| Primary Care Provider: | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Referred by: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Age |  | | | | Birthdate | | | | / / | | | | | Sex | | | | |  Female  Male | | | | | | | | | | | | | |
| Marital Status | | | | |  Single | | | | |  Married to: | | | |  | | | | | | | | | | | |  Other: | | | | | | |  | | | | | |
| If < age 18: | | | | | Mother: | | | | |  | | | | | | | | | | | | | Father: | |  | | | | | | | | | | | | Phone:\_\_\_\_\_\_\_\_\_ | | |
| **Patient’s Employer** | | | | | | | | |  | | | | | | | | | | | | | | | | | Occupation | |  | | | | | | | | | | | | |
| Work Phone | | | |  | | | | | | | | Ext: | | | |  | | | | | |
| Address | |  | | | | | | | |  | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | |  |
|  | | Street & Suite # | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | State | | | | Zip |
| **Emergency Contact**  (Not in your household) | | | | | | | | | |  | | | | | | | | | | | | | | | | Relationship to Patient | | | | | |  | | | | | | | | |
| Home Phone | | | | |  | | | | | | Work Phone | | | | | | |  | | | | | | | Other Phone | | | | | |  | | | | | | | |
| **Primary Health Insurance Co** | | | | | | | | | | | | | | | N/A | | | | | | | | | | | | | | | | | | | | | | | | | |
| Policy # | |  | | | | | | | | | | | Group # | | | | | | |  | | | | | | | | Ins. Phone | | | | | | | |  | | |
| **Insured**: Name | | | | | |  | | | | | | | | | | | DOB | | | |  | | | | | | | | Employer | | | | | |  | | | |
| **Secondary Health Insurance Co** | | | | | | | | | | | | | | | | | N/A | | | | | | | | | | | | | | | | | | | | | | | |
| Policy # | |  | | | | | | | | | | | Group # | | | | | | |  | | | | | | | | Ins. Phone | | | | | | | |  | | |
| **Insured**: Name | | | | | |  | | | | | | | | | | | DOB | | | |  | | | | | | | | Employer | | | | | |  | | | |
| **Health Care Information may be released to (Next of Kin): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **Date** | | | | |  | | | | | | |

**Narra Dermatology and Aesthetics Statement of Privacy Practices**

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your obligation and your rights.

**Protecting your Healthcare Information**

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will be properly disclosed or released.

**Collecting Protected Healthcare Information (PHI)**

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

**Disclosure of your Protected Healthcare Information**

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

**Your Rights as our Patient**

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for you copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

**Narra Dermatology and Aesthetics**

**Acknowledgment of Receipt of Statement of Privacy Practices**

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Narra Dermatology. The statement of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Narra Dermatology reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

|  |  |  |
| --- | --- | --- |
| **ADDITIONAL DISLOSURE AUTHORIZATION** | | |
| ***In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is “NO”. Without indicating “YES” in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)*** | | |
| **Spouse Only** | **YES** | **NO** |
| **Any Member of my immediate family: (Spouse, Children, Children’s Spouses)** | **YES** | **NO** |
| **An Member of my extended family: (Parents, Grandchildren)** | **YES** | **NO** |
| **Other:** | **YES** | **NO** |
| **Name of patient (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Personal Representative’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Representative’s Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

**OFFICE USE ONLY BELOW THIS LINE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Acknowledgement Not Obtained** | | | | | |
| **Provided Prior to Treatment?** | **YES** | | **NO** | | **Date Statement Provided:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Reason for not obtaining patient signature** | |  | | **Needed more time to review Statement** | |
|  | | **Wanted to consult another person before signing** | |
|  | | **Physically unable to sign** | |
|  | | **No reason offered** | |
|  | | **Other:** | |

**Financial Policy**

**Insurance:**

As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit.

If your insurance company denies coverage, or we otherwise do not receive payment 30 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay.

**Financial Arrangements:**

Because we realize that every person’s financial situation is different, we provide a variety of payment options.

For your convenience, the following options are available:

- Cash or check (returned checks will be subject to a $45 returned check fee. If the check is returned for any reason, your account becomes due and payable within 7 days.)

- Visa, MasterCard & American Express – For your convenience, we have made arrangements to accept payment by Visa, MasterCard, Discover and American Express.

Payment Plan – Arrangements may be made, if you qualify for a monthly payment plan for balances of $200.00 and more upon request and at the approval of our Doctor and Financial Coordinator.

**Appointments/Cancellations:**

We gladly reserve appointment times for you as a courtesy; we will attempt to remind you of your appointment by calling and/or emailing you 2 days prior to confirm your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient’s valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. We reserve the right to charge $75 for appointments cancelled or broken without 48 hours advance notice.

**Patient/Parent/Guardian Responsibility:**

I understand that whoever accompanies my child to their dermatology appointment has authorization to consent to medical care as needed, and is responsible for payment of medical services.

I acknowledge my responsibility for payment of all dermatology services provided by Dr. Narra in accordance with the practice’s fees and terms.

In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment. They may then seek reimbursement from the other parent.

**Late Fees:**

I understand that my account becomes delinquent if not paid within 30 days after billing and at that time the unpaid balance will be subject to a finance charge of $25 per month. Any further delinquency will warrant the account being assigned to a collection agency and possibly the addition of further charges.

**Medical Records and Form Completion**

When requesting copies of your medical records, we ask that the request be made in writing. Please see our front office for the Medical Records Transfer Form. We will make every attempt to have the records available within 5 to 7 days of the request. Depending upon chart size and format of the record duplications, a fee of up to $25.00 may be applied after the first copy of the chart. In addition, a charge of $45 will be applied for filling out insurance claim forms such as L&I Claims, AFLAC Claims etc.

**Assignment and Release:**

I authorize payment to be made directly to Dr. Narra by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card on File Policy**

Narra Dermatology is committed to making our billing process as simple and easy as possible. Starting January 2016, we will require that all patients provide a credit card on file with our office. When you come in, we will scan your card with a card reader. It will store your card number in a secure, compliant location in your electronic medical record. For security reasons only the last four digits will be visible to our staff. Credit Cards on File will be used to pay co pays when you come in to the office and account balances after your insurance processes your claim.

When we receive the Explanation of benefits (EOB) from your insurance company, we will enter this information in our system. At that time, if your total amount owed is less than $50, we will email you with a notification that we are processing that payment. If it is over $50, we will send out a statement showing your total amount owed. If you wish to give a different method of payment than the card on file or if you would like to split your balance into multiple payments, please call our office at 425-677-8867 to make arrangements. Two weeks later, (from the date listed on your statement), we will run the credit card on file for the full amount owed. If your payment is declined, we will call you to let you know at that time. If you do not return our call within one week a $45 declined payment fee will be applied and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the last statement and at that time the unpaid balance will be subject to a finance charge of $25 per month. Any further delinquency will warrant the account being assigned to a collection agency and possibly the addition of further charges.

I give permission for Narra Dermatology charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion. I also understand I may discontinue this authorization at any time by giving written notice to Narra Dermatology.

I realize this information will be used solely for the purpose of consumer withdrawal.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

**Name**: **Date of Birth**: **Date:**

**History of Present Illness** (Reason for Visit): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worse When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Better When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Severity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems** (check if a current problem)

\_\_\_\_\_ Eyes \_\_\_\_\_ Musculoskeletal  
 \_\_\_\_\_ ENT & Mouth \_\_\_\_\_ Neurological  
 \_\_\_\_\_ Respiratory \_\_\_\_\_ Psychiatric  
 \_\_\_\_\_ Gastrointestinal \_\_\_\_\_ Endocrine (diabetes, thyroid)  
 \_\_\_\_\_ Genitourinary \_\_\_\_\_ Cardiovascular  
 \_\_\_\_\_ Hematologic/Lymphatic \_\_\_\_\_ Allergic/Immunologic  
 \_\_\_\_\_ Skin

**Medical History**  Self Father Mother Children Siblings

Melanoma \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Skin Cancer \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Eczema \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Psoriasis \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Lupus \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Other \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 HIV/AIDS \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Hayfever \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Asthma \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Arthritis \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Diabetes \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Hepatitis \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 High Blood Pressure \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Kidney Disease \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Liver Disease \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Mental Illness \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Migraine \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Osteoporosis \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Stroke \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Thyroid Disease \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Bowel Disease \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
  
 Current Meds \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
How many blistering sunburns have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you exposed to toxic chemicals in your job or hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you traveled outside the U.S. in the last 2 years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Meaningful Use**

**Name**: **Date of Birth**: **Date:**

**Ethnicity**

* Hispanic or Latino
* Not Hispanic or Latino
* Declined or Unspecified

**Race**

* American Indian/Alaskan Native
* Asian
* Native Hawaiian/Other Pacific Island
* Black/African American
* White
* Declined or Unspecified

**Preferred Language**

* English
* Spanish
* Declined or Unspecified

**Smoking Status**

* Never been a smoker
* Former smoker
* Current sometimes smoker
* Current every day smoker

**Do you drink alcohol?**

* Yes
  + If yes \_\_\_\_\_\_\_drinks per day
* No
* Occasionally

**Do you use IV drugs?**

* Yes
  + If yes, What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

*\*These questions are included to comply with new Federal Health guidelines—we are required to ask for this information.*